

HACKENSACK UNIVERSITY MEDICAL CENTER

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below

Patient Name	Date of Birth	Social Security Number
Address (Street, City, State, Zip Code)		Telephone Number
The following individual or organization is authorized to make the disclosure: <input type="checkbox"/> Hackensack University Medical Center <input type="checkbox"/> Other (please specify) _____		
This information may be disclosed to and used by the following individual or organization: <input type="checkbox"/> Hackensack University Medical Center <input type="checkbox"/> Other (please specify) _____		
Treatment dates:	Purpose of Request:	

The following information is to be disclosed: (please check)

- | Yes | No |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/>Discharge Summary |
| <input type="checkbox"/> | <input type="checkbox"/>History & Physical Examination |
| <input type="checkbox"/> | <input type="checkbox"/>Consultations (including psychiatric evaluations) |
| <input type="checkbox"/> | <input type="checkbox"/>Operative Report or Procedure Reports |
| <input type="checkbox"/> | <input type="checkbox"/>Emergency Department Record |
| <input type="checkbox"/> | <input type="checkbox"/>Laboratory Reports (including drug screens) |
| <input type="checkbox"/> | <input type="checkbox"/>Radiology or Imaging Reports |
| <input type="checkbox"/> | <input type="checkbox"/>Cardiac Studies |
| <input type="checkbox"/> | <input type="checkbox"/>Interdisciplinary Records (Progress Notes) |
| <input type="checkbox"/> | <input type="checkbox"/>Medication Records |
| <input type="checkbox"/> | <input type="checkbox"/>Nursing Notes |
| <input type="checkbox"/> | <input type="checkbox"/>Physician Orders |
| <input type="checkbox"/> | <input type="checkbox"/>Complete Record |
| <input type="checkbox"/> | <input type="checkbox"/>Other _____ |

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I do not specify an expiration date, event or condition, this authorization will expire in six months.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

If I have any questions about disclosure of my health information, I can contact the Systems Manager in the Health Information Management Department at 201-998-2075.

Signature of Patient or Legal Representative	Date
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If Signed by Legal Representative, Relationship to Patient